TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
North Texas Pain Recovery Center

Respondent Name
WC Solutions

MFDR Tracking Number
M4-17-1018-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 134.600 (p) does not specify that preauthorization is required for a behavioral health evaluation."

Amount in Dispute: $573.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation submitted and included with the requestor's Medical Dispute Resolution request does not provide time spent."

Response Submitted by: WC Solutions c/o Edwards Claims Admin

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2016	96150	$573.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the requirements for medical claim submission.
3. 28 Texas Administrative Code §134.600 sets out requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 18 – Duplicate claim/service

- W3 – Additional reimbursement made on reconsideration
- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for code 96150 – "Health and behavior assessment, each 15 minutes face to face with the patient; initial assessment."

   The insurance carrier denied disputed services with code 151 – "Payment adjusted because the payer deems the information submitted does not support this many services." The denial of 197 – "Payment denied/reduced for absence of precertification/authorization" was not listed at reconsideration of the claim. Therefore, this denial will not be discussed during the Division's review process.

   28 Texas Administrative Code §133.210 (c) states in pertinent part,

   > In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
   >
   > (1) the two highest Evaluation and Management office visit codes for new and established patients: **office visit notes/report** satisfying the American Medical Association requirements for use of those CPT codes;

   Review of the CPT code description detail finds "each 15-minute direct, face-to-face session with the patient."

   Review of the "Behavioral Health Assessment, May 17, 2016" finds no indication of beginning or ending time to support the total number of units (16) or four hours of direct face-to-face contact.

   Based on the Divisions review of the submitted records, the carrier's denial is supported.

2. As the requirements of Rule 133.210 (c)(1) were not met, no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 29, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.